WHEN PLIGHT MAKES RIGHT: THE FORENSIC ABUSE SYNDROME

Ian Freckelton

The Forensic Abuse Syndrome

The first use of syndrome evidence in the courts occurred in the 1970s in the United States, the home of their creation. There are two kinds of syndrome evidence: that which focusses upon the behaviour of the victim and that which purports to explain the behaviour of the assailant. The best known are:

- rape trauma syndrome;
- battered woman syndrome (battered wife/spouse syndrome);
- child abuse syndrome (incorporating battered and battering child syndromes);
- premenstrual syndrome;
- parent abuse syndrome;
- post-traumatic stress syndrome;
- pathological gamblers' syndrome;
- combat stress syndrome; and
- Vietnam Veterans' syndrome.

Many others have been postulated to the courts by lawyers, most of them to explain why a person the victim of or charged with a serious criminal offence has behaved in a way which departs from the standards sanctioned by the rest of the community and expected of its members. This legal technique has developed into a recognisable and socially diagnosable phenomenon, ironically, if the parlance of psychological syndromes is adopted, itself a syndrome: the "forensic abuse syndrome".

The syndromes listed above have a number of shared characteristics. All of them psychopathologise conduct which is the product of stress. Many of them have a legitimacy within the therapeutic context, but attempts have been made to translocate each one of them out of their accustomed sphere into the courts to exculpate their sufferers from criminal conduct or to prove that criminal conduct (such as sexual assault) has occurred. This may be termed "the forensic abuse syndrome": the propensity to classify conduct as an example of a socially unsatisfactory phenomenon (domestic violence, parent beating, child molestation, rape etc) and for the purposes of a criminal trial to seek to draw inferences in respect of a particular individual from studies of victims' or assailants' reactions statistically compiled in the therapeutic context. The inferences sought to be drawn may be ideologically alluring but in the case of the syndromes are likely to be scientifically dubious to say the least.

The Forensic Challenge

A controversial issue in evidence law in the 1990s is whether expert evidence in relation to battered woman syndrome, rape trauma syndrome, abused child syndrome or one of the other "novel psychological evidence" syndromes should be admissible and, if so, how far such testimony should be permitted to go. The Supreme Courts of Canada, South Australia and New South Wales have recently admitted evidence relating to women who have been classified as the long-term victims of abuse. The Supreme Court of Tasmania has been less welcoming. This has enabled female defendants to avail themselves of the defences of duress and self-defence, and might also be used to help establish provocation in a murder case.

The controversies over the admissibility of syndrome evidence range over a number of issues, including whether the information provided by the experts in fact is impermissible evidence as to credibility and whether it genuinely constitutes evidence about a reliable area of expert endeavour.

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1 Barrister-at-Law, Victoria, NSW and the ACT. The author acknowledges the helpful comments and criticisms of Stephen Odgers and Hugh Selby. However, all responsibility for views expressed and errors made remains his alone.
The proponents of the evidence maintain that it is counterintuitive or myth-dispelling, that is to say that it plays the vital function of disabusing tribunals of fact of misapprehensions about the ways people behave when they suffer traumas that are not within the ordinary experience of most of the population. Leading feminist critics, however, have objected that "syndromisation" medicalises healthy human reactions to male oppression in the form of physical or sexual abuse (see for example, Sheehy, Stubbs & Tolmie 1992; Stubbs 1991 & 1992; Walus-Wigle & Melroy 1988).

This paper examines the courtroom reception accorded to the two most prominent syndromes, battered woman syndrome and rape trauma syndrome, and analyses the legitimacy of some of the claims put forward on behalf of these forms of novel psychological evidence. In doing so it propounds the view that the syndromes are not sufficiently scientifically validated to constitute areas of expert endeavour for most forensic purposes. It argues for a middle ground in relation to the admissibility of counterintuitive expert evidence, and it addresses issues of principle that surround the categorisation of victims of post-traumatic stresses.

**The Term "Syndrome"**

The term "syndrome" is well known within the medical fraternity as being "a running together", a "sundromos" in the Greek, or, as the Oxford English Dictionary puts it "a concurrence of several symptoms in a disease".

Normally a syndrome is regarded as being identifiable when a collection of symptoms occurs together so often that they provide a recognisable clinical entity. In referring to the term "organic mental syndrome", for instance, DSM-111-R (American Psychiatric Association 1987) defines it as "a constellation of psychological or behavioral signs and symptoms without reference to etiology" (my emphasis) and distinguishes "organic mental disorder" as an organic mental syndrome where the etiology is known or presumed.

Little has been written about the use of the term "syndrome" in relation to "battered woman syndrome" or "rape trauma syndrome" and it may be that those who coined the terms would object to their nomenclature being analysed in terms of the medical model and in particular the divisions employed by DSM-111-R. However, at first glance there is an immediate anomaly because the use of the term "syndrome" is primarily employed within the medical community and in that context it generally carries with it the idea of a set of recognisable characteristics typical of a disease or clinical entity but whose etiology is unknown. However, the essence of the forensic application of the syndromes listed above is that inferences as to aetiology are drawn, rightly or wrongly, from recognition of symptoms characteristic of the syndromes.

On occasions there is much in a name because nomenclature conveys both denotation and connotations. From a forensic point of view, one of the difficult issues about receiving syndrome evidence is that in so doing a tribunal of fact may be misled by the cloak of social psychological observation being portrayed in what may be perceived as the more plausible dress of medicine, a respectability to which the inappropriately named "syndrome" may not be entitled. When it comes to the exercise of the prejudice/probative discretion (see Freckelton 1993d), this may become important.

**Battered Woman Syndrome**

Dr Lenore Walker (1979, 1984, 1989, 1991) is the first author credited with describing the cycle of violence frequently met in the relationships of battered women with their battering spouses. She did so in her 1979 book, *The Battered Woman*. In her 1984 follow-up, *The Battered Woman Syndrome* she reported the results of a study involving 400 battered women, her research being designed to test empirically the theories expounded in her earlier work. She argued that the battered woman syndrome occurs where a woman is the victim of a three phase cycle:

"[T]here are three distinct phases associated in a recurring battering cycle: (1) tension building, (2) the acute battering incident, and (3) loving contrition. During the first phase, there is a gradual escalation of tension displayed by discrete acts causing increased friction such as name-calling, other mean intentional behaviours, and/or physical abuse. The batterer expresses dissatisfaction and hostility but not in an extreme or maximally explosive form. The woman
attempts to placate the batterer, doing what she thinks might please him, calm him down, or at least, what will not further aggravate him. She tries not to respond to his hostile actions and uses general anger reduction techniques. Often she succeeds for a little while which reinforces her unrealistic belief that she can control this man.

The tension continues to escalate and eventually she is unable to continue controlling his angry response pattern. "Exhausted from the constant stress, she usually withdraws from the batterer, fearing she will inadvertently set off an explosion. He begins to move more oppressively toward her as he observes her withdrawal ... Tension between the two becomes unbearable" (Walker, 1979, p.59). The second phase, the battering incident, becomes inevitable without intervention. Sometimes, she precipitates the inevitable explosion so as to control where and when it occurs, allowing her to take better precautions to minimise her injuries and pain.

"Phase two is characterised by the uncontrollable discharge of the tensions that have built up during phase one" (p.59). The batterer typically unleashes a barrage of verbal and physical aggression that can leave the woman severely shaken and injured. In fact, when injuries do occur it usually happens during this second phase. It is also the time police become involved, if they are called at all. The acute battering phase is concluded when the batterer stops, usually bringing with its cessation a sharp physiological reduction in tension. This in itself is naturally reinforcing. Violence often succeeds because it does work.

In phase three which follows, the batterer may apologize profusely, try to assist his victim, show kindness and remorse, and shower with gifts and/or promises. The batterer may believe at this point that he will never allow himself to be violent again. The woman wants to believe the batterer and, early in the relationship at least, may renew her hope in his ability to change. The third phase provides the positive reinforcement for remaining in the relationship, for the woman."

Dr Walker defines a battered woman as a woman who has gone through the battering cycle at least twice. Thus, the syndrome relates to the circumstances in which the woman lives that, objectively speaking, are dangerous and in the course of which she exhibits a passivity or "learned helplessness" that arises from her domestic experiences and her perceptions of the danger that she faces.

The syndrome is not claimed itself to comprise the explosive reaction by a woman to a threat that she perceives, a significant omission which is often overlooked. It simply describes the effects of a lifestyle of a woman who is the subject of repeated domestic violence from which she finds herself unable easily to extricate herself. Walker (1984, 1989, 1991), Easteal (1992, 1993), Sheehy, EA, Stubbs, J and Tolmie (1992) and others usefully chronicle a variety of social circumstances which militate toward the victim of such violence remaining to suffer it again and again.

Walker (1991), however, has also argued that the psychiatric diagnosis of Post-Traumatic Stress Disorder (PTSD - see American Psychiatric Association 1987) "comes closest to describing battered woman syndrome, the group of psychological symptoms often observed after a woman has repeatedly experienced physical, sexual and or serious psychological abuse". She has maintained that, as with other syndromes, such as rape trauma syndrome and combat war syndrome, there are core symptom patterns observable in addition to ones which are syndrome-specific. For what she describes as "both political and clinical reasons" Ms Walker continues to support the use of the diagnostic category of PTSD for those suffering battered woman syndrome although she acknowledges that "the generic criteria may not be specifically tailored to measure the entire collection of psychological symptoms that constitutes battered woman syndrome" (Walker 1991: 27).

The Legal Background

From Australia's point of view, the most significant case for the evolution of the admissibility of expert evidence relating to battered woman syndrome is that of Lavallee v The Queen (1990) 55 CCC (3d) 97, a powerful decision of the Supreme Court of Canada. At her trial on a charge of murder the accused woman relied on the defence of self-defence. The evidence showed that the accused had shot the man with whom she had been living for several years in the back of the head as he was leaving
the room after he had allegedly assaulted and threatened her. In a lengthy statement to police, the accused admitted the shooting but said that she had shot the deceased because he had threatened to kill her when their visitors had left and because she was scared as a result of all the other times that he had beaten her.

A psychiatrist testified that the accused felt at the relevant time that unless she "defended" herself and reacted in the way that she did she would be killed. On appeal the Supreme Court of Canada affirmed the admissibility of the evidence given by the psychiatrist, holding that the mental state of the accused could not properly be appreciated without this evidence. The court rejected the assertion that this was a matter of human nature about which the jury was sufficiently knowledgeable without the assistance of expert evidence.

In the leading judgment Wilson J held the evidence admissible:

"How can the mental state of the appellant be appreciated without it? The average member of the public (or of the jury) can be forgiven for asking: Why should a woman put up with this kind of treatment? Why should she continue to live with such a man? How could she love a partner who beat her to the point of requiring hospitalization? We would expect the woman to pack her bags and go. Where is her self-respect? Why does she not cut loose and make a new life for herself? Such is the reaction of the average person confronted with the so-called "battered woman syndrome". We need to understand it and help is available from trained professionals" (at 112).

Her Honour referred to the pervasiveness of myths and stereotypes likely to have currency in the jury room if not dispelled by the counterintuitive evidence available from expert witnesses. She found that the mental state of the accused at the time she pulled the trigger could not be understood except in terms of the cumulative effect of months or years of brutality. Her Honour drew attention to the fact that, because of the cyclical and predictable pattern of violence inherent in a battering relationship, the battered woman may anticipate violence accurately earlier or more accurately than the non-battered victim.

She noted the phenomenon of "learned helplessness", a term coined by Dr Charles Seligman, the psychologist who developed the theory by experimentation on animals, and also referred to the concept of "traumatic bonding", a phenomenon observed between hostages and captors, battered children and their parents, concentration camp prisoners and guards and batterers and their spouses. She referred to a theory expounded by Ewing (1987: 19-20) that the subjugated person becomes more and more dependent upon their assailant, even possibly coming to identify with the attacker and feeling that they deserve the maltreatment that they are receiving. The affective bond between battered victim and battering assailant intensifies and the victim of the violence becomes increasingly powerless. Her Honour noted that environmental factors, such as lack of job skills, the presence of children to care for and fear of retaliation by the assailant may all also play a role in causing the woman not to leave the abusive situation.

Wilson J summarised as follows the principles upon which she regarded expert testimony is to be admitted in such cases:

1. Expert testimony is admissible to assist the fact-finder in drawing inferences in areas where the expert has relevant knowledge or experience beyond that of the lay person.

2. It is difficult for the lay person to comprehend the battered-wife syndrome. It is commonly thought that battered women are not really beaten as badly as they claim; otherwise they would have left that relationship. Alternatively, some believe that women enjoy being beaten, that they have a masochistic strain in them. Each of these stereotypes may adversely affect consideration of a battered woman's claim to have acted in self-defense in killing her mate.

3. Expert evidence can assist the jury in dispelling these myths.
4. Expert testimony relating to the ability of an accused to perceive danger from her mate may go to the issue of whether she "reasonably apprehended" death or grievous bodily harm on a particular occasion.

5. Expert testimony pertaining to why an accused remained in the battering relationship may be relevant in assessing the nature and extent of the alleged abuse.

6. By providing an explanation as to why an accused did not flee when she perceived her life to be in danger, expert testimony may also assist the jury in assessing the reasonableness of her belief that killing her batterer was the only way to save her own life." (125; see also Martinson et al 1991)

In Australia's first major case in which the syndrome was prayed in aid (Runjancic & Kontinnen v R (1991) 53 A Crim R 362) the appellants had formed a subservient menage a trois relationship with a man for whom both worked as prostitutes. He beat another woman seriously and was to a degree assisted in the process by the appellants. At the trial their counsel sought to call an experienced psychologist to give evidence of the appellants suffering from "the battered woman syndrome" in order to advance the defence of duress in respect of their participation in the assault. It was argued on their behalf that the evidence would assist the jury to evaluate the effect of the violence perpetrated against the appellants upon their actions in respect of the victim in the case and would "eliminate the risk of the appellants being condemned by popular mythology about domestic violence" (371). Without hearing from the psychologist, the trial judge ruled the evidence inadmissible.

The South Australian Court of Criminal Appeal was referred to a substantial volume of North American literature on the subject. King CJ held that the syndrome

"now appears to be a recognised facet of clinical psychology in the United States and Canada. It emerges from the literature that methodical studies by trained psychologists of situations of domestic violence have revealed typical patterns of behaviour on the part of the male batterer and the female victim, and typical responses on the part of the female victim. It has been revealed, so it appears, that women who have suffered habitual domestic violence are typically affected psychologically to the extent that their reactions and responses differ from those who might be expected by persons who lack the advantage of an acquaintance with the result of those studied" (366).

In addressing the appropriateness of admitting such evidence King CJ looked to the Frye criterion of general acceptance of the theory within the relevant scientific community (see Frye v United States 293 F 1013 at 1014 (1923); Freckelton 1993a, 1993c). Curiously, he did not refer to the Frye test by name although the language employed is unmistakably that of Frye:

"An essential prerequisite to the admission of expert evidence as to the battered woman syndrome is that it be accepted by experts competent in the field of psychology or psychiatry as a scientifically established facet of psychology. This must be established by appropriate evidence" (366).

King CJ then cited the following passage from People (New York) v Torres, 488 NYS 2d 358 at 363 (1985) in support of his approach:

"Upon careful reflection and analysis, however, it is the opinion of this Court that the theory underlying the battered woman's syndrome has indeed passed beyond the experimental stage and gained a substantial enough scientific acceptance to warrant admissibility. According to Dr B, numerous articles and books have been published about the battered woman's syndrome; and recent findings of researchers in the field have confirmed its presence and thereby indicated that the scientific community accepts its underlying premises" (367).
as well as the following passage from the Court of Appeals of New Mexico in State (New Mexico) v Gallegos, 719 P 2d 1268 at 1274 (1986) which followed People (New York) v Torres:

"In our case, the trial court apparently found the psychologist qualified to testify in her area of expertise. The court evidently also determined that the "battered wife syndrome" had gained general recognition and acceptance in the field of psychology" (see also Lavallee v R (1990) 55 CCC 3d 97).

Ironically, the United States Supreme Court in Daubert v Merrell Dow Pharmaceuticals (No.92-102, 1993, US Lexis 4408) has since held that the Frye test is no longer the criterion for admissibility of "novel scientific evidence" and that courts must instead focus upon "reliability" of theories and techniques to determine whether they cross the threshold of providing assistance to the trier of fact. They must take into account whether the theory or technique can be or has been tested; whether it has been subjected to peer review and publication as a means of increasing the likelihood that substantive flaws in methodology will be detected; the known or potential rate of error and the existence and maintenance of standards controlling the technique's operation; and finally whether a technique has gained general acceptance within the scientific community.

King CJ held that as the defence of duress had been raised by the defence, issues before the court included (a) whether the will of the two women had actually been overborne and (b) whether a person of reasonable firmness in their situation would have been so overborne. The expert evidence relating to battered woman syndrome proffered by the psychologist was "designed to assist the court in assessing whether women of reasonable firmness would succumb to the pressure to participate in the offences". Thus, it was relevant to the issues to be decided. Similarly, as it also served to explain why even a woman of reasonable firmness would not escape the situation rather than participate in criminal activity, it was also relevant.

Bollen J in the same case took a different approach while arriving at the same result. He found the battered woman syndrome to be "an organised branch of knowledge in which" a person may qualify as an expert (Clark v Ryan (1960) 103 CLR 486 at 491, 501-2) and purported to follow a decision of the DC Circuit Court of Appeals in Dyas v United States, 407 A 2d 626 at 633 where the Court stated:

"1. The subject matter "must be so distinctly related to some science, profession, business or occupation as to be beyond the ken of the average layman...";
2. The witness must have sufficient skill, knowledge or experience in that field or calling as to make it appear that his opinion or inference will probably aid the trier in his search for the truth ...; and
3. Expert testimony is inadmissible if "the state of the pertinent art or scientific knowledge does not permit a reasonable opinion to be asserted even by an expert."

His Honour expressed the view that "This text, sometimes expressed in different words with the same meaning seems to command agreement amongst writers in America"(372) and held that, subject to the Clark v Ryan requirement (see above), it was "apposite for South Australia".

Bollen J also canvassed the possibility that the expert evidence might be excluded on the basis that its value might be outweighed by its prejudice. His Honour expressed the view that battered woman syndrome evidence, when led for the defence, may result in a focus on the batterer but was sanguine about the employment of appropriate trial safeguards. In addition, he expressed the view that the right of the accused to put his or her defence "is so fundamental that it must tip the scales in favour of the probative value of the proffered testimony over its potentially prejudicial impact" (373).

Ironically, the second Australian case to accept expert evidence relating to battered woman syndrome involved one of the women to benefit from its admission in the first case -Erika Kontinnen (R v Kontinnen, unreported, Supreme Court of South Australia, 30 March 1992). She had killed in his
sleep the male with whom she had been living in a menage a trois after he had threatened to kill her, another woman and a child. On the basis of expert evidence about her suffering from battered woman syndrome, her defence of self-defence was upheld and she was acquitted.

The third Australian case to admit expert evidence of battered woman syndrome was that of \textit{R v Hickey}, unreported, Supreme Court of NSW, 14 April 1992, in which Cynthia Hickey was acquitted of the murder of her former de facto husband. No objection was taken by the Crown to the admission of expert evidence about the syndrome in the context of her having stabbed the deceased after he had assaulted and attempted to strangle her. However, the evidence given by the forensic psychologist was of very short compass, scarcely cross-examined and directed almost exclusively toward explaining the victim's dependency and "why she would continue to live with such a person" (Transcript, p.124). The case is almost valueless in terms of precedent.

\textbf{Rape Trauma Syndrome}

Many of the issues canvassed above in relation to battered woman syndrome arise also in the context of women's experience of rape trauma syndrome. Its genesis was slightly before that of battered woman syndrome with Ann Burgess and Lynda Holmstrom (1974, 1977) coining the term in the mid-1970s to describe the emotional, behavioural and psychological reactions typically exhibited by female victims of sexual assault (see \textit{Commonwealth v Gallagher}, 547 A 2d 355 (Pa 1988)). Rape trauma syndrome has always been more mainstream than battered woman syndrome so far as psychiatrists and psychologists are concerned, rape being explicitly recognised as a potential cause of post-traumatic stress disorder (see American Psychiatric Association, 1987: 248) and the symptoms being more readily referable to a stressor than battered woman syndrome.

Burgess and Holmstrom's thesis was based on an analysis of the symptoms exhibited by 92 female victims of rape selected from 146 patients admitted during a one year period between 1972 and 1973 to the emergency ward of Boston City Hospital. They described a syndrome with two phases: first, the victim experiences disorganisation in lifestyle with emotional reactions ranging from fear, humiliation and embarrassment to anger and a desire for revenge:

"Although fear of physical violence and death dominates the victim's feelings, self-blame is also very prominent. During this phase, when the victim feels the impact of the rape most severely, she may exhibit one of two widely divergent emotional styles. In the expressed style, feelings of fear, anger, and anxiety are manifested through crying, sobbing, smiling, restlessness, and tenseness. In the controlled style, feelings are masked by a calm, composed, or subdued demeanour. The second phase involves a long-term process of physical and emotional reorganization. This phase begins two to three weeks after the attack. Symptoms may include change in residence, travel to sources of support in other cities, nightmares, and various phobic reactions. Although all victims do not experience the same symptoms in the same sequence, victims consistently experience the disorganization phase. Many victims thereafter experience mild to moderate symptoms in the reorganization process. Few victims report no symptoms" (Dwyer 1988: 1064).

In this division, they met general agreement from Sutherland and Scherl (1970: 503) who differed in that they divided victims' reactions into three phases but in general terms agreed with Burgess and Holmstrom. Early follow-up studies were critical of the methodology of the initial work (see Kilpatrick et al 1979: 658; McCombie 1976: 137; Notman & Nadelson 1976: 408) but in general terms supported the early researchers' conclusions, while refining the nature of the victims' tensions and anxieties during the longer-term post-sexual assault period (see Lauderdale 1984: 1371ff). Fischer (1989: 705-6) notes that

"Subsequent research refined the symptoms associated with these short- and long-term reactions to a rape and estimated the prevalence of those symptoms in the general population of victims. There are numerous empirical studies of victims of rape completed to date [1989] which demonstrate that victims' reactions affect four areas: anxiety or fears, depression, social adjustment and social functioning. Most rape victims have strong rape-related fears, both immediately after the rape and long term. Other researchers have found that depressive
symptoms are frequently part of the long-term reaction to rape. Victims often have problems in carrying out their major social roles, including work and social relationships. Many victims also report that rape disrupts their sexual functioning for a substantial period. 

The psychological studies also document the severity of the trauma caused by rape. Six months after the rape, the majority of rape victims still experience a distinct "core of distress". More than forty per cent of victims at fifteen to thirty months after the rape suffer from sexual dysfunction, restricted social interaction, suspicion, fears, and depression. A variety of psychological symptoms are present in rape victims three years after the rape, leading researchers to conclude that victims may never achieve complete recovery from the rape. Additionally, the results of these studies indicate that knowing the assailant does not improve the rape victim's recovery process, and may even present additional problems for the victim.

However, as Ball (1993) has pointed out, victims' reactions to even the most extreme of assaults vary enormously. Apparent "psychic numbing" after an assault can be regarded as an early indication of post-traumatic stress disorder or as a perfectly normal (and potentially quite transitory) reaction to a stressor.

**United States Courts' Approach to Rape Trauma Syndrome**

United States' courts have been split on the admissibility of rape trauma syndrome evidence (see 42 ALR 4th 879) with three holding it inadmissible (Minnesota: State v Saldana, 324 NW 2d 227 (Minn 1982); State v McGee, 324 NW 2d 232 (Minn 1982), Washington: State v Black, 109 Wash 2d 336, 745 P 2d 12 (1987); Pennsylvania: Commonwealth v Gallagher, 547 A 2d 355 (1988) and at least ten holding it admissible for at least a limited purpose (Arizona: State v Radjenovich, 674 P 2d 333 (1983); State v Huey, 145 Ariz 59, 699 P 2d (1985) (en banc); California: People v Bledsoe, 36 Cal 3d 236, 681 P 2d 291 (1984) (en banc); Colorado: People v Hampton, 746 P 2d 947 (colo 1987) (en banc); Indiana: Simmons v State, 504 NE 2d 575 (Ind 1987); Henson v State, 535 NE 2d 1189 at 1191 (Ind 1989); Iowa: State v Gettier, 438 NW 2d 1 (Iowa 1989); Kansas: State v Marks, 647 P 2d 1292 (1982); State v McQuillen, 236 Kan 161, 689 P 2d 822 (1984), aff'd 239 Kan 590, 721 P 2d 740 (1986); Maryland: State v Allewalt, 308 Md 89, 517 A 2d 741 (1986); Missouri: State v Taylor, 663 SW 2d 235 (Mo 1984); Montana: State v Liddell, 211 Mont 180, 685 P 2d 918 (1984); Wisconsin: State v Robinson, 146 Wis 2d 318, 431 NW 2d 165 (1988)). Four state Supreme Courts have admitted such evidence when the victim is a child, and not committed themselves on the issue of its admissibility in respect of adult victims (Delaware: Wheat v State, 527 A 2d 269 (Del 1987); Hawaii: State v Kim, 64 Haw 598, 645 P 2d 1330 (1982); Oregon: State v Middleton, 294 Or 427, 567 P 2d 1215 (1982); Vermont: State v Catsam, 148 Vt 366, 534 A 2d 184 (1987)).

Most United States commentators (see, for example, Fischer 1989, Donohue 1988, Massaro 1985) have concluded that rape trauma syndrome satisfies the criteria for admissibility laid down in Frye v United States 293 F 1013 at 1014 (1923) in that it has achieved general acceptance within the relevant field of knowledge. It is not as yet clear what impact the Merrell Dow decision will have upon this status.

An indication may be found in the stance of Watson (1988) who argues that a focus on the validity and consistency aspects of the syndrome casts doubt upon whether the symptoms of the syndrome accurately demonstrate that rape was their cause and whether many other factors might not cause the same symptoms. She joins others in querying whether the syndrome can validly be translated from a treatment to a diagnostic tool.

In the leading United States case of People v Bledsoe, 681 P 2d 291 (1984) the court made the distinction that while rape trauma syndrome is generally recognised as having validity within the scientific community in which it is used, it may not be relied upon by that community for the purpose for which the prosecution wishes to lead it - to prove that a rape actually occurred. It analogised expert testimony on rape trauma syndrome to hypnotically induced testimony and testimony on the results of polygraph tests and held that the scientific evaluation of rape trauma syndrome had not reached a level of reliability that surpassed the quality of common sense evaluation that could be undertaken by lay jurors. The court noted that the symptoms characteristic of the syndrome may follow any psychologically traumatic event. It pointed out that the syndrome describes only symptoms that
occur with some frequency, but it makes no pretence of covering the field of all sexual assaults - the
task of determining whether the alleged victim really was a victim in the sense alleged by the
prosecution remains that of the body best equipped to undertake it - the jury.

For the most part, expert evidence relating to the experience of rape trauma syndrome has been
regarded as complying with Rule 702 of the United States Federal Rules of Evidence which prescribes
that testimony must be helpful to the trier of fact; this is generally interpreted to mean that it must be
beyond the ken of the average lay person. In particular, the existence of "rape myths" is regularly cited
to justify evidence being given on matters which might otherwise be regarded as within the province of
the average juror to appreciate.

There has been an evolution in the scope of and purposes for which rape trauma syndrome has been
admitted in United States courts with an emerging focus for the admissibility determination on the
purpose for which the testimony is tendered. Generally testimony offered to explain elements of the
complainant's behaviour which might be considered harmful to the prosecution case has been held
admissible. These include delay in reporting, failure to make an early complaint, emotional flatness
after the incident, memory lapses, inability to provide a clear description of assailant and hostile
attitude toward police investigators.

Much of the 1980s' controversy in the United States came to be directed toward whether the expert
should be permitted to proceed to the next step and express the view that the complainant suffered from
the syndrome.

Although it was suggested in Commonwealth v Gallagher, 547 A 2d 355 (Pa 1988) that such
evidence in fact was about the witness' credibility and so invaded the province of the jury, most courts
have regarded it as helpful to "rebut common misconceptions about the presumed behavior of sexual
assault victims" (see, eg, State v Robinson, 146 Wis 2d 315 at 326, 431 NW 2d 165 at 169
(1988)). It may be that such evidence, where it is led to be counterintuitive or to combat unconscious
assumptions and prejudices only becomes possible where the defence has "opened the door" by
arguing that the behaviour of the complainant after the alleged assault is inconsistent with that of a
"real victim". Often, however, the expression "rape trauma syndrome" is not employed by the expert or
the court and the evidence is simply about general clinical symptomatology of victims in similar
circumstances. With this approach I would have no quarrel. Expert testimony has generally not been
permitted to evaluate or comment on the complainant's credibility.

Fischer (1989: 717ff) usefully divides the approaches of United States courts into the following
categories:

- Expert testimony limited to explaining the general theory behind the syndrome and listing the
  constellation of symptoms and behaviour that constitute its diagnosis in an individual (the
  approach favoured by Watson 1988);

- Expert testimony listing the victim's behaviour and symptoms but not giving an opinion about
  the meaning of those symptoms;

- Expert testimony that the victim's symptoms are consistent with either rape trauma syndrome
  or post-traumatic stress disorder;

- Expert testimony that the victim suffers from rape trauma syndrome or post-traumatic stress
  disorder; and

- Expert testimony to the effect that a victim suffers from rape trauma syndrome or post-
  traumatic stress disorder, is telling the truth and/or was raped.

The categories are in ascending order of magnitude of incursion into the province of the jury -
determining whether by reason of the victim suffering rape trauma syndrome, the victim's account of
her experience is likely to be true and so that she was forced into non-consensual sexual intercourse.
There have been occasions where rape trauma syndrome evidence has been rejected on the basis that its prejudicial value outweighs its probative qualities. For instance, in State v Saldana (324 NW 2d 227 (1982 Minn) an appellate court upheld the exclusion of expert evidence on typical familial sexual abuse symptoms and behaviour. It characterised a counsellor's proposed evidence as of no help to the jury and bearing with it an extreme danger of unfair prejudice. Permitting a person in the role of an expert to suggest that because the complainant exhibited some of the symptoms of the rape trauma syndrome, she had therefore been raped, unfairly prejudiced the defendant by creating an aura of special reliability and trustworthiness, declared the court. Since jurors of ordinary abilities are competent to consider the evidence and to determine whether the incident occurred as alleged by the prosecution, the danger of unfair prejudice outweighed any probative value that such evidence would have.

In another important decision, that of Henson v State (535 NE 2d 1189 at 1191 (Ind 1989) the Indiana Supreme Court held that a judge had erred at first instance in excluding expert opinion evidence led by the defence that the behaviour of the complainant, in drinking and dancing at the same bar at which she claimed she had been raped earlier the same evening, was inconsistent with the behaviour of rape victims and did not match the profile of a person suffering from rape trauma syndrome. The Court in Henson found the evidence probative on the issue whether a traumatic rape occurred and held that it would be "fundamentally unfair" (1193) to preclude the defense's use of rape trauma syndrome evidence if such evidence were permissible to the prosecution (see Economou 1991).

**Australian and New Zealand Law**

There is little caselaw on the admissibility of rape trauma syndrome in Australia and New Zealand. Forensic use of the syndrome has thus far been largely confined to criminal injuries compensation hearings. In New Zealand the Court of Appeal in R v Accused ([1989] 1 NZLR 714) was asked in relation to a subcategory of rape trauma syndrome involving children to hold that "child sexual abuse accommodation syndrome" evidence was admissible. It refused to do so.

Summit (1983) described the "child sexual abuse accommodation syndrome" as existing when children "learn to accept" a status quo of intrafamilial sexual abuse. He identified secrecy; helplessness; entrapment and accommodation; delayed, conflicted and unconvincing disclosure; and retraction of disclosures as typcial manifestations of the syndrome (see also Meyers 1989; Gardner 1992; Freckelton 1993a). The Crown had sought to call as a witness a psychologist, who was also a school guidance counsellor, to counter the suggestion arising from cross-examination that the complainant had fabricated her allegations. She gave evidence that the complainant had exhibited behaviour consistent with the characteristics of sexually abused children.

The Court held that it had not been properly established that children subject to sexual abuse demonstrate

"certain characteristics or act in peculiar ways which are so unmistakable that they can be said to be concomitants of sexual abuse; or that expert evidence in this field was able to indicate with a sufficient degree of compulsion, features which establish that the evidence of the complainant was indeed truthful; nor did the psychologist describe the tests she undertook and the reactions of other children from her own experience, or have recourse to the specialist literature to confirm her opinion"(at 720-1).

The Court noted that many characteristics of a victim said to be consistent with a syndrome may have other explanations:

"While the characteristics mentioned by the psychologist were said to be consistent with those the witness had come to know as the characteristics of sexually abused children, some at least of those characteristics, for example, pen tattoos on hands and arms, cigarette burns and cuts and lack of eye contact, may very well occur in children who have problems other than sexual abuse"(at 721).
The Tasmanian Court of Criminal Appeal in *Ingles v R* (Unreported, 4 May 1993) had occasion to address the same issue in 1993. It rejected the argument that a psychiatrist's evidence about the characteristics of child sexual abuse accommodation syndrome generally was relevant as going to the issue of consent on the basis that absence of complaint in sexual cases is not properly to be regarded as probative of consent. Zeeman J held that as "evidence of a recent complaint does no more than act as a buttress to the credibility of a complainant, an explanation for an absence of such a complaint does no more than relate to credibility." The Court left open the possibility of expert evidence to explain delay in making complaint when evidence of recent complaint is actually introduced, which in *Ingles v R* it was not.

The respondent had also argued that the psychiatrist's evidence was relevant as being probative of the complainant having been the victim of sexual abuse. The Court held that the evidence in fact did no more than impermissibly support the complainant's credibility. Crawford and Zeeman JJ made reference to the New Zealand decisions of *R v B* ([1987] 1 NZLR 362) and in particular *R v Accused* ([1989] 1 NZLR 714) where child sexual abuse accommodation evidence was regarded as admissible in principle if it was established that "a particular child has exhibited traits displayed by sexually abused children generally" and if the evidence demonstrates "in an unmistakable and compelling way and by reference to scientific material that the relevant characteristics are signs of sexual abuse" (at 720). Their Honours noted that the requirements enunciated in *R v Accused* had not been fulfilled and Zeeman J held:

"There was no evidence of characteristics or actions clearly and unmistakably the concomitants of sexual abuse. The evidence of Dr Sale indicated that the conduct of the complainant was consistent with that to be expected from a child the subject of sexual abuse, but in circumstances where that conduct was equally consistent with no real sexual abuse having occurred."

Both judges expressed reservations about the correctness of the analysis in *R v Accused*, Zeeman J, for instance, suggesting that "it might be said to go further than sound principle justifies."

The most significant aspect of the decision of the Tasmanian Court of Criminal Appeal in *Ingles v R* is the Court's view that the expert evidence which had been elicited from the psychiatrist in fact did nothing other than bolster the complainant's credibility, a function long precluded. It appears that recent relevant Canadian authorities were not cited to the Court and it is also noteworthy that the basis for the expert evidence was not adequately laid in the course of the complainant's evidence. However, the Court's disinclination to admit counterintuitive evidence, expert evidence directed toward disabusing jurors of myths and misimpressions, and its preparedness to take the analysis the next step to determine what relevance the expert's opinions would actually have to the jury function is most important. If this line of reasoning is more generally adopted, syndrome evidence will be admitted comparatively rarely in Australia and very rarely in the case of "rape trauma syndrome" and "child sexual abuse accommodation syndrome".

**When Flight Does Not Make Right**

A particular legal problem confronts women who kill their spouses. It arises out of the traditional requirements of the defence (1) of provocation that there be a close temporal connection between provocation and violence and that the provocative conduct be of such a kind that would deprive an "ordinary person" of self-control; and (2) of self-defence that the accused must have believed on "reasonable grounds" that what she did was necessary and that excessive force not have been employed. It has been suggested that these requirements impose male values and characteristic male reactions upon women who have been the longterm victims of physical and emotional violence at the hands of male batterers (see Sheehy, Stubbs and Tolmie 1992, for a useful summary of the literature). Commentators (see, for example, Stubbs 1991; Easteal 1993) have argued that this is inequitable to women, failing to take into account the cumulative impact of domestic assault upon a female victim's psyche and the ability of a woman to predict likely behaviour of battering spouse.

The law has changed comparatively little to permit the characteristics personal to a particular accused to be taken into account to assist in the defences of provocation and self-defence. The New South Wales legislature reworked the provocation defence in 1982 (see Weisbrot 1982) and the
reformulated definition of permissible self-defence in *Zecevic v R* (1987) 162 CLR 645 at 661 reduced the need to prove imminence of reaction to threat. Similarly, the focus upon the continuing reality of the fear of the accused after a threat was what was focussed upon by White J in *Zanker v Vartzokas* (1988) 34 A Crim R 11 at 14. However, factors such as the exceptional pugnacity of the defendant, sensitivity about sexual impotence, self-induced intoxication, pregnancy, delusion, or particular sensitivity to allegations have been held not to be characteristics of the "reasonable man" or the "ordinary man" for the purposes of the provocation defence. Furthermore, the High Court decision of *Stingel v R* (1990) 50 A Crim R 186 at 198 makes it clear that the test in relation to provocation is "objective" and does not take account of factors personal to the accused save age - not even gender. This is to be contrasted with a jurisprudence in relation to Aborigines has evolved over the past forty years to deal with the need to have regard to issues that are personal to the defendant (see *Patipatu* (1951-1976) NTJ 18 at 20; *MacDonald* (1951-1976) NTJ 186 at 190; *Muddarubba* (1951-1976) NTJ 317 at 322; *Balir* (1951-1976) NTJ 633 at 637; *Jabarula v Poore* (1989) 42 A Crim R 479 at 487; *Mungatopi* (1991) 57 A Crim R 341; *Rankin* [1966] QWN 10; *Jabarula v Poore* (1989) 42 A Crim R 479 at 487-8).

If characteristics personal to the accused woman were able to be taken account, thus rendering the tests of self-defence and provocation into ones that focused upon the reasonableness of the accused's actions and beliefs given their particular circumstances and emotional condition, the need to "psychopathologise" battered women's mental states would not exist. To a considerable degree, the syndromes represent a medical fiction constructed to deal with a stance of the law that insists upon supposedly objective notions of ordinariness and reasonableness. The policy consideration that even those in untenable domestic situations be discouraged from availing themselves of violent forms of self-help has effectively denied any room for exploration of factors personal to the accused woman unless she can be shown to be suffering from a mental illness.

**Scientific Validity of the Syndromes**

Not all women who are raped or the subject of domestic violence will behave in the same way immediately after assault or in their longer term attempts to recover from it. However, many aspects of their behaviour will be common and these "symptoms" are said by proponents of the syndromes' legitimacy to be indicative of the fact that they have been the victim of rape or the fact that they have been repeatedly battered. The problem in relation to this contention lies in the fact that the symptoms of rape trauma syndrome and battered woman syndrome are for the most part not rape- or domestic violence-specific but are characteristic generally of persons who have suffered a major trauma which has caused a stress disorder.

From a forensic point of view, this makes evidence about the inferences that can be drawn from the existence or absence of post-traumatic stress disorder or syndrome symptoms extremely dangerous. Accurately, the existence of post-traumatic stress disorder signs in a person claiming to have been raped or battered can only be said to be consistent with the person's having experienced a major stressor, of which rape or longer term domestic violence are potential examples.

**Admissibility Issues**

**The Common Knowledge Rule**

Both *R v Lavallee* and *R v Runjancic and Kontinnen* are examples of a flexible interpretation of the "common knowledge rule" focussing upon the "helpfulness" of expert opinion evidence. For Australia this approach is of comparatively recent origin (see Freckelton 1993c) and was most notably found in the High Court decision in *R v Murphy* (1989) 167 CLR 94. The clear view of a majority of the High Court was one of preparedness to discard inflexible criteria for determining when jurors had acquaintance with matters of common knowledge. Rather, if expert evidence would assist the tribunal of fact to understand matters of which it would otherwise have only some ken, then it was admissible. This opens the Australian door to evidence designed to dispel myths and misapprehensions that otherwise might play an unacknowledged role in juror deliberations (see Sheehy, Stubbs & Tolmie 1992, at 375ff).

**Self-Serving Evidence/Ultimate Issue Rule**
Once evidence about the phenomenon of learned helplessness and altered perception arising out of the cycle of domestic violence, is placed before a court, the next question is whether the fact that a particular individual suffered from the cycle is to be allowed and then if that is permitted, whether the woman at the relevant time would have perceived it as necessary to attack her assailant or to react in the way that she did?

At one level such expert evidence from a psychologist, psychiatrist or sexual assault counsellor is doing little more than bestowing legitimacy to the accused's claim that she believed that she had to behave in the way that she did. It is to the effect that there is verisimilitude to the accused woman's assertion that she believed herself under such threat that she had to react with violence. And yet, save in the case of those suffering from mental illness and seeking to avail themselves of the defences of insanity or diminished responsibility, expert evidence has not been admitted on the issue of the accused's credibility.

The rationale for this preclusion has traditionally been that assessment of the truthfulness of the version of events contended for by an accused person is an archetypal jury function, and not one for expert witnesses unless the accused is suffering from intellectual impairment as a result of mental illness or congenital or other disability. Thus, such expert evidence is declared inadmissible both because it trespasses upon the ultimate issue which is the province of the tribunal of fact and because it purports to assess credibility, a task not for an expert but once again for the tribunal of fact.

If my preferred position, that of admitting expert evidence in terms of generalities in order to promote the removal of misapprehensions on the part of the jury, were to obtain, then the problems in relation to expert evidence as to matters of credibility and expert evidence trespassing on the ultimate issue would not be raised. This is the approach taken by a number of recent Canadian decisions (R v C (1990) 57 CCC (3d) 522; R v J (1989) 53 CCC (3d) 64; R v R (1992) 73 CCC (3d) 225 at 230; R v D (1992) 74 CCC (3d) 481) in which grave reservations have been expressed about the propriety of expert witnesses descending from the general to the particular when giving evidence about common behaviour of victims in order to infer the likelihood of a crime having been committed or the complainant in a sexual assault case telling the truth.

An Area of Expertise?

A further preliminary admissibility issue is whether they constitute the syndromes constitute fields of expert endeavour that qualify clearly for admissibility. While they may be of significant clinical utility in a therapeutic context, can they be satisfactorily removed from the domestic violence counsellor or sexual abuse counsellor's room to the forensic setting?

To what extent are the syndromes to be classified as a "medical" phenomenon? Are their sufferers properly to be described as suffering in any sense from a psychiatric illness found in the pages of DSM-111-R or ICD-10? After all, the bottom line of the battered woman syndrome assertion is that the woman suffers at the crucial time from a distorted reality which explains her explosion out of her "learned helplessness" into retaliatory (and on occasions apparently disproportionate) violence against her batterer. Given her mind-set which has been altered by her victimisation, for legal purposes it must be reasonable for her to believe it to be necessary that she attack her assailant rather than adopt another less confrontational response. For her to be able to avail herself of the defence of self-defence in the Australian context, she must be able to demonstrate that she believed "on reasonable grounds" that it was "necessary" for her to commit the act of violence.

Or is it more accurate to classify both battered woman syndrome and rape trauma syndrome as socio-psychological phenomena with certain broad characteristics, which may or may not be suffered by a particular individual? This is a vital distinction because the vast majority of women who are battered, and this is a substantial percentage of the cohabiting population, do not turn violently on their assailants and seriously injure or kill them. Little attention appears to have been given in the published literature to this aspect of the battered woman phenomenon. To be sure many females are the victims of a continuing cycle of domestic violence. As well many of those who kill their spouses have experienced the "Walker cycle". But the vast majority of those who experience the Walker phenomena deal with their problems in a non-violent way. Moreover, they would not suggest that their capacity to
perceive the world around them is so distorted by the assaults committed upon them that they are justified in taking violent action which is not proportional to the threat which others looking on objectively would see as posed against them. Schuller and Vidmar chronicle the critical literature usefully:

"The applicability of the learned helplessness paradigm to battered women has also been questioned (see Faigman 1986). When women in battering relationships were compared with a sample of battered women who had terminated the relationship, little support for learned helplessness was found in Walker's (1984) research data (McDonald 1989). Furthermore, other researchers (for example, Gelles & Straus 1988), relying on survey methodologies, have argued that although the notion of learned helplessness seems applicable to some battered women, the majority of battered women engage in a variety of responses in an attempt to end the abuse. Consistent with this view, a number of studies have documented a wide range of coping responses that are utilized by battered women (Browne 1987; Dobash & Dobash 1979; Ewing 1987; Martin 1976; Pagelow 1981)."

The syndromes' status as "scientific", "valid" and "reliable" and the purposes for which the expert evidence is admitted are crucial. Do all women who are battered or raped exhibit the same reactions? We know that they do not, but that a broad cross-section do. How fuzzy are the edges of the syndromes? Are the phases of the "battering cycle" identified by Walker sufficiently distinct to be scientifically recognisable? Are the criteria governing experience of battered woman or rape trauma syndrome sufficiently precise to be able to distinguish adequately the sufferer of the syndrome from the person who is not afflicted with its all of characteristics? Can any of the characteristics be absent and the woman still be properly regarded as a sufferer of the syndromes? In State v Griffiths (1980) 610 P 2d 522, for instance, expert evidence on battered woman syndrome was disallowed on the ground that there was not sufficient history of abuse, while Sheehy, Stubbs and Tolmie (1992: 387) point out the conceptual paradox when a woman fights back against her assailant and later maintains in the forensic context that she had been the longterm victim of "learned helplessness", permitting her to come under the umbrella of battered woman syndrome.

What is the degree of overlap between the syndromes and other syndromes or mental disorders? For instance, Rosewater (1987) has warned that the "symptoms" presented by the battered woman have been confused with, and resulted in misdiagnosis of, schizophrenia or borderline personality disorder. Schuller and Vidmar (1992) maintain both that "Aside from general problems of inaccuracy of diagnosis, the diagnosis of battered woman syndrome could be exacerbated by methodological problems similar to that which plagues the diagnosis of child sexual abuse" and that "the reliability of diagnosis of battered woman syndrome for forensic use urgently needs both legal and scientific attention". Frazier and Borgida commented in 1988 (117) that "No research has actually examined whether clinicians, presented with the same data, would independently agree on a diagnosis of rape trauma syndrome for a particular client."

What controls and other safeguards have been utilised by the researchers to ensure that battered women who have committed acts of violence against their assailants really have at the relevant time suffered from a distorted sense of reality about the threat posed to them or someone close to them? Given the dissonance between the passivity and "learned helplessness" that are central to battered woman syndrome and the explosion of violence that transforms them into defendants in the courts, this question requires a compelling answer.

Is the work done by Walker and Burgess and Holmstrom and the others who argue in favour of the syndromes reproducible? Does the battered woman have to be living with the assailant to qualify? What if she has not lived with him for six months or a year? Does that affect the required number of cycles, or need there be two further cycles before she once again qualifies as a sufferer from the syndrome? What of the fact that Walker found that only 65 per cent of the cases involved a tension-building phase prior to the battering and in only 58 per cent of cases did a period of loving contrition follow the battering incident. It would appear that these results confirm what might be expected, namely, that violence and its effects vary enormously from one battering relationship to another.

Until all of these questions can be answered clearly, it is my view that the expert evidence given in relation to battered woman syndrome and rape trauma syndrome ought not to be admitted save in terms of the recognised trauma phenomena about which psychologists, psychiatrists, sexual assault counsellors, social workers, criminologists (Easteal 1993) and others can speak. From a forensic point
of view they are not "areas of expertise" and may well fail the Merrell Dow test. Experts' evidence should not be in terms of the experience of a particular individual, such as the specific accused person or victim, but in terms of what is known about victims' reactions generally. This leaves the next logical step to the jury.

**Policy Issues**

Aside from the admissibility issues canvassed above, the battered woman defence in particular has been the subject of no small amount of criticism:

- it has been suggested that recognising a battered woman's defence may undermine the deterrent effect of the criminal law and encourage the use of self-help;

- it has been suggested that the possibility for fraudulent claims is too high;

- definitional problems of who constitutes a battered woman have been highlighted;

- it has been argued that recognition of battered woman syndrome may lead to the call for recognition of other victimisation syndrome defences;

- it has been maintained that expert evidence on the battered woman syndrome will prejudice the jury against the deceased and in favour of the accused woman;

- it has also been argued that the use of the syndrome will further stereotyping of women by emphasising the weaknesses and passive tendencies of the battered woman; and

- the propensity of the syndrome to cast its sufferer in a medical light rather than as the victim of male oppression has been the subject of objection (See Note 1992 for a useful summary of such arguments).

The forensic use of battered woman syndrome has been to provide jurors with an alternative perspective or "social framework" (Walker and Monahan 1987) for determining whether a woman's beliefs and actions were contextually reasonable. It provides information relevant to the inferences that jurors will need to draw about the time of the woman's act of aggression. The difficulty occurs when expert witnesses impute to a defendant not overtly suffering a psychiatric illness a psychopathology that would legitimise what might otherwise be designated an understandable, though not justifiable, act of retaliation against intolerable male oppression.

If a woman determines not to leave a battering relationship because of economic deprivation, because of fears of stigma, because of well-founded anxiety about her safety and that of her children, she may well be making a rational, healthy decision. That is in no way to condone what has brought about her circumstances. A vital policy issue, however, is whether her violence should be exculpated when finally her desperation turns to violence. Should her anger and violence turned against her male aggressor be cloaked in the woolly, illness-resonating terminology of syndromes or should she be treated at sentencing stage with some understanding and should the factors that have kept her and others like her be addressed? If refuges were more available, if police were more responsive, if the legal system were not so alienating, if violence were more readily condemned by our culture, the criminal justice system included, women might perceive themselves as having more options than turning upon their oppressors when their guard is down. Then the problem of male violence directed against women would be addressed at its roots.

**Conclusions**

The advantage offered by both battered woman syndrome and rape trauma syndrome is that they explain why a victim of domestic and/or sexual violence does not always behave in the way that a member of the population with no experience of such victimisation would expect. But the dubiously psychopathological nomenclature of "syndrome" is not necessary for such evidence to be brought usefully before a court. A criminologist, sociologist, rape crisis worker or member of a community policing squad might well all be able to testify that battered women acquire a learned passivity which
leads them to stay in relationships when commonsense would dictate that they leave. In fact a Canberra criminologist has already provided this form of evidence (Easteal 1993). Such witnesses might well also be able to testify that the fact that a woman does not report a rape immediately or in the short term does not seem stressed by it or exhibit any number of other characteristics which the uninitiated would associate with a rape victim does not mean that she has not been raped.

I suggest that the ill occurs when the medical term "syndrome" is adopted and when what are therapeutic tools are employed for purposes for which they are not suited. So long as they are used to explain to women that they are not at fault for having stayed in a battering relationship or for not reacting hysterically after a rape and immediately after a sexual assault reporting the matter to the police, they serve a legitimate purpose. So too do they serve a useful function in pointing out to jurors that responses of victims are complex and diverse in the extreme and that negative inferences ought not necessarily to be drawn from the absence of what the laity might regard as "normal" or necessarily from the presence of what might appear "surprising" forms of behaviour.

However, the function of these "syndromes" is misapplied when they are set in concrete and used for purposes for which they were never initially envisaged. To allow an expert to put before a jury the inference that because a complainant's behaviour is of a certain kind that therefore a crime has or has not been committed is dangerous and ought to be precluded at the least as more prejudicial than probative and in all probability as not emanating from an "area of expertise".

If this reasoning is correct, evidence that there are commonly encountered reactions in women subject to cycles of violence or who have been sexually assaulted should be permitted. (In accordance with the call by Sheehy, Stubbs and Tolmie (1992), a variety of expert witnesses, including non-psychologists and psychiatrists could give such evidence). Evidence that such a phenomenon constitutes a "syndrome" should not. Nor should evidence that a particular woman fits in with the profile of women the subject of domestic violence or the victim of sexual assault. Nor should any supposedly expert evidence that such women's behaviour is indicative of people who have, for example, been sexually assaulted or who have not been sexually assaulted. At the extreme end of cases, evidence should never be admitted that a woman in a particular woman's position would have been likely to have misconceived the threat objectively posed to her because she "suffered from a syndrome". All of these latter steps are matters for jurors, with which, disabused of the myths and misapprehensions to which they might otherwise have been prey, they are quite capable of dealing. It is important that the "forensic abuse syndrome" phenomenon that has proliferated in the United States and resulted in ill-conceived, if well-meaning, attempts to redress gender imbalance not be further imported into the Australian legal system.

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